Baker

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38548

FILED DEC 9 1943

Registration District No. 170 Primary Registration District No. 3033 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County LACLede
(b) City or town LEBANON (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 602 N. MONROE (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 19 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County LACLede
(c) City or town LEBANON (If outside city or town limits, write "RURAL")
(d) Street No. 602 N. MONROE (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ELLA SMITH
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife JOHN A. SMITH
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. (Month) 19 (Day) 1865 (Year)

8. AGE: Years 78 Months 2 Days 13 If less than one day hr. min.

9. Birthplace GREEN CO (City, town, or county) ARK. (State or foreign country)
10. Usual occupation HOUSEWIFE
11. Industry or business

MOTHER FATHER
12. Name H. C. SHAVER
13. Birthplace GREEN CO (City, town, or county) ARK (State or foreign country)
MOTHER
14. Maiden name MARY R PERRY
15. Birthplace MEMPHIS (City, town, or county) TENN (State or foreign country)

16. (a) Informant Otis V. Smith
(b) Address Washington, D.C.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-4-43 (Month) (Day) (Year)
(c) Place: burial or cremation LITTLE CREEK CEM.
18. (a) Signature of funeral director Palmeira
(b) Address Lebanon Missouri
19. (a) Dec 1-43 (Date received local registrar) (b) Grace Rowe (Registrar's signature)

1093

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 2 year 1943 hour 12 minutes 50 A.M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Paralytic Stroke	
Due to: Cardiac Decompensation	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. L. Bohrer (M. D. or other) DO.
Address LEBANON MO Date signed 11-4-43

Received .....

Laclede County Health Unit

File No. 11-43-170

Date Filed 12-8-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Allyn Dethrage

Licensed Embalmer No. 4333

P. O. Address Lebanon Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
P I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 170 Primary Registration District No. 3023 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ella Smith
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ Years
7. Birth date of deceased aug (Month) 19 (Day) _____ (Year)
8. AGE: Years 78 Months 2 Days _____ If less than one day: _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country) ark.
10. Usual occupation _____
11. Industry or business _____

MOTHER / FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__; that I last saw h_____ alive on _____, 19__; and that death occurred on the date and hour stated above. Duration
Immediate cause of death Paralytic Stroke
Due to cardiac decompensation
Due to Cerebral Hemorrhage
Other conditions (Include pregnancy within 3 months of death) Sarc
Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature O. L. Erhart (M. D. or other) MD.
Address _____ Date signed 11/3/43

38548